IN THE SUPERIOR COURT OF THE STATE OF DELAWARE
IN AND FOR NEW CASTLE COUNTY

GODFREY P. AREGE, III,	)	
	)	
Appellant,	)	
	)	
v.	)	C.A. No. 05A-05-006 WCC
	)	
STATE OF DELAWARE, DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISION OF LONG TERM CARE RESIDENT'S PROTECTION,	)	
	)	
Appellees.	)	

Submitted: May 22, 2006
Decided: August 30, 2006

MEMORANDUM OPINION

Appeal from the Department of Health and Social Services, Division of Long Term Care Residents Protection. REVERSED.

Godfrey Paul Arege; 16 West Saxony Drive; New Castle, Delaware 19720. *Pro Se* Appellant.

James T. Wakley; Department of Justice; 820 N. French St., 6th Floor; Wilmington, Delaware 19801. Attorney for Appellee.

CARPENTER, J.

Introduction

Before this Court is Godfrey Paul Arege, III's ("Appellant" or "Mr. Arege") appeal from the Adult Abuse Registry Hearing with Delaware Health and Social Services ("DHSS"), Division of Long Term Care Resident's Program (the "Division"), in which the hearing officer found that Mr. Arege committed acts of neglect against an elderly resident of a group home. Upon review of briefs filed in this matter, this Court finds the hearing officer's decision is not supported by substantial evidence and is hereby REVERSED.

Facts

As a counselor employed by Community Systems, Inc., Mr. Arege was assigned to assist residents in a group home on the evening of December 5, 2004, and into the early morning of December 6, 2004. On December 6, 2004, at approximately 1:50 a.m., Mr. Arege discovered Francis McCloskey in respiratory distress, and thereupon called the facility director to inform her of Mr. McCloskey's condition. The director advised Mr. Arege to call 911, which he did, and to begin to perform CPR on Mr. McCloskey. At approximately 2:30 a.m., the paramedics arrived, and after attempting to revive Mr. McCloskey, he was pronounced dead.

As a result, a report was sent to DHSS outlining the incident. Upon investigation, DHSS found that Mr. Arege's conduct was sufficient to establish

neglect pursuant to 16 Del. C. § 1131, and placed Mr. Arege's name on the Adult Abuse Registry (the "Registry") for five years. Mr. Arege appealed this decision, and after a hearing held on April 20, 2005, the hearing officer issued an opinion on May 5, 2005 upholding the placement of Mr. Arege's name on the Registry, but reducing the time frame to three years (the "Decision"). On May 19, 2005, Mr. Arege filed a timely appeal with the Prothonotary's Office of the Superior Court.[1] Both parties have had an opportunity to fully brief the issues, and upon review of the record and briefs, the Court issues this opinion.

Standard of Review

An appeal from an Adult Abuse Registry Hearing is reviewed on the record by this Court to determine whether the decision is supported by substantial evidence and free from legal error.[2] Substantial evidence may be characterized as evidence that a

[1]The Court notes that a motion to dismiss was filed by the Appellee. While the Appellant filed an incomplete notice of appeal, the error of failing to place "Superior Court" as the appellate court is a matter of form over substance and is not a sufficient basis to disallow the appeal to move forward. The appeal document was filed timely in the correct court, and docketed by the Prothonotary's Office upon receipt. Lastly, the Appellee is not prejudiced by the delay in correcting the error, and as such, the Court will determine the appeal on its merits.

[2]*Munyori v. Division of Long Term Care Residents Protection,* 2005 WL 2158508 (Del. Super. Ct.), see also, *Johnson v. Chrysler Corp.,* 213 A.2d 64, 66 (Del. 1965); *Gen. Motors Corp. v. Freeman*, 164 A.2d 686, 689 (Del. 1960) ("The position of the Superior Court . . . on appeal is to determine only whether or not there was substantial evidence to support the findings of the Board. If there was, these findings must be affirmed."); *Fed. Street Fin. Serv. v. Davies*, 2000 Del. Super. Ct. LEXIS 286, at *6.

reasonable mind accepts as adequate support for the conclusion.[3] In this capacity, the Court does not weigh evidence, determine questions of credibility, or make findings of fact.[4] When applying the substantial evidence standard, the Court must consider the record in a light most favorable to the prevailing party, "resolving all doubts in its favor."[5] If the record supports the hearing officer's findings, the Court should accept those findings even though, acting independently, the Court might reach a different conclusion.[6]

Discussion

"Neglect" is defined, in pertinent part, as the "[l]ack of attention to physical needs of the patient or resident including, but not limited to toileting, bathing, meals and safety."[7] Since there is no bright-line test to establish if a person committed neglect, it can be evidenced by "demonstrat[ing] a breach of a standard of care,

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[3] *Majaya v. Sojourners' Place*, 2003 WL 21350542 (Del. Super. Ct.), at *4; *Fed. Street Fin. Serv.*, 2000 Del. Super. Ct. LEXIS 286, at *7; see also *Oceanport Indus. v. Wilmington Stevedores, Inc.*, 636 A.2d 892, 899 (Del. 1994); *Holden v. State*, 2005 WL 3194481 (Del. Super. Ct.), at *2.

[4] *Johnson*, 213 A.2d at 66-67 ("On appeal from the Board, however, the Superior Court does not sit as a trier of fact with authority to weigh the evidence, determine questions of credibility, and make its own factual findings and conclusions.").

[5] *Gen. Motors Corp. v. Guy*, 1991 WL 190491 at *3 (Del. Super. Ct.).

[6] *H & H Poultry Co., Inc. v. Whaley*, 408 A.2d 289, 291 (Del. 1979).

[7] 11 Del. C. § 8564; 16 Del. C. §1132.

violation of a policy, or any act or course of conduct that a fact-finder determines to be a lack of attention to a nursing facility resident's physical needs."[8] Lastly, if there is a finding of abuse or neglect after an investigation by DHSS, that person's name must be placed on the Registry.[9]

In the case at hand, it is clear that the hearing officer was troubled by the inconsistency between Mr. Arege's testimony and the Interdisciplinary/Progress Notes ("I/P Notes"),[10] written by the Appellant the morning of the incident, that detailed the events that unfolded on the night in question.[11] The hearing officer concluded:

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[8]*Holden v. State*, 2005 WL 3194481 (Del. Super. Ct.), at *2-3 (Neglect is established through analyzing "a course of conduct that rises to a level of substantial evidence."); *Lynch v. Ellis*, 2003 WL 22087629 (Del. Super. Ct.).

[9]11 Del. C. § 8564.

[10]The I/P Notes are a written account of what took place regarding Mr. McCloskey during Mr. Arege's shift. They were written by Mr. Arege the morning after the incident, which according to Mr. Arege, is the typical procedure in that facility.

[11]The hearing officer stated in his decision, "[T]he Appellant's testimony in this case is found to not be credible. The Appellant's statement under oath varied so distinctly from the written version that it leads to a conclusion that the Appellant was presenting a sanitized version of events that would be palatable to this hearing officer." Decision at 4. Thus, it is presumed the facts are lifted directly from the I/P Report, which states as follows:

> At around 1:50 a.m. the staff called the program director to inform her that [Francis] was not breathing. The program director informed me to call the 911 who in turn directed me to do CPR as per the directions on the phone. I followed the dispatcher's instruction until they arrived at the house; at that time they took over. They worked on him for approximately [thirty] 30 minutes and were not successful in reviving him.

> 1) Francis (Mr. McCloskey) ceased breathing sometime prior to 1:50 a.m.; 2) instead of immediately calling 911, the Appellant called the program director for instructions; 3) after receiving instructions, the Appellant then called 911 to report Francis' condition; and 4) the Appellant did not begin CPR until instructed by 911 dispatchers.[12]

Based on the above factual conclusions, coupled with the definition of neglect, the hearing officer reached the conclusion that Mr. Arege did in fact commit neglect. However, this Court is unable to make that same leap.

While the Court is not allowed to substitute its judgment for that found by the hearing officer simply because the Court disagrees with the conclusion, it must be able to find something in the record to support a finding that Mr. Arege engaged in a course of conduct which equated to neglect. The record here is devoid of such evidence. Specifically, the record before the hearing officer failed to establish Mr. Arege was inattentive to Mr. McCloskey's needs, or that he violated any established standard of care. First, it is important to note that there was no independent evidence presented by the State regarding the events of that evening. The only testimony provided at the hearing was that of Mr. Arege. Equally astonishing is that the other key evidence critical to the State's case, the I/P Notes drafted by Mr. Arege the

[12]Adult Abuse Registry Administrative Hr'g Tr., 5, April 20, 2005 (hereinafter, "Hr'g Tr.").

morning of the incident, were never even formally entered into evidence.[13] While formal rules of evidence need not be followed, the Court notes the State as well as the Appellant were represented by very competent lawyers who appreciate the importance of establishing a clear record for an appeal. So at best, the only record before the Court is the testimony of Mr. Arege whose credibility was questioned by the hearing officer and the treatment notes that were never introduced into the record. To add further insult to the Court, it was provided a transcript in which there were 130 instances of "inaudible" references in a 47-page transcript. For the State to argue that this record supports the finding of the hearing officer is insensible.

In spite of this handicap, it is clear that the State failed to provide testimony or transcription of the 911 conversation with Mr. Arege and the 911 officers which

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[13]During the hearing, the following exchange transpired while Mr. Arege discussed the I/P Notes:

PHEBE YOUNG:	Beginning on 12/5/04 and I believe that the incident in question is recorded on the second page of that, correct, it is at 1:50?
HEARING OFFICER:	Are you admitting this into evidence?
PHEBE YOUNG:	I'm going to.
HEARING OFFICER:	That's fine, thank you.
ANTHONY FIGLIOLA:	For the record.
PHEBE YOUNG:	Is this your handwriting?
GODFREY AREGRE:	It is.

Hr'g. Tr. at 7-8. The above exchange is the only place in the record the Court could find a reference to entering the I/P Notes into evidence. At no point does either party ever properly introduce the I/P Notes into the record, though Mr. Arege testifies that it is his writing and explains entries on the document.

would have shed light on the conduct that evening; it did not provide testimony of the paramedics to ascertain the condition of Mr. McCloskey at the time they arrived or the interaction with the Appellant; it did not provide testimony of the program director to determine what the protocol within the facility was or if Mr. Arege called her prior to calling 911; it did not provide testimony from any other staff members at the facility;[14] and it did not establish whether there was any written policy or procedures within the facility or independently created by DHSS that were violated by Mr. Arege.[15] With some minimal effort the State perhaps could have met their burden. However, their bare bones presentation makes it difficult to support the conclusions of the hearing officer.

The facts that were established by the State indicate that Mr. Arege found Mr. McCloskey in a poor physical state and that, since he was not a trained medical person, he made a reasonable decision to call the facility director to ascertain what medical steps he should undertake. He, thereafter, called 911 and performed CPR in

[14]In fact, the Court is not clear if additional staff was present at the facility at the time of this unfortunate incident. If Mr. Arege was alone, that fact supports Mr. Arege's reason for calling the director for medical advice. In the alternative, if Mr. Arege was accompanied by additional staff, they should have testified as to what occurred.

[15]The closest the State gets to establishing a standard is testimony by Mr. Arege regarding his CPR training, which the Court finds is not helpful in determining if Mr. Arege's actions rose to the level of neglect.

an effort to aid Mr. McCloskey until the paramedics arrived. These actions alone do not constitute inattentiveness, and likewise do not constitute neglect.

As previously indicated, a finding of neglect requires either a breach of the standard of care or a lack of attention to the physical needs of a resident.[16] The Court has not found substantial evidence to support a finding of neglect, even when the evidence is viewed in a light most favorable to the Appellee. As a result, the Court must reverse the Decision and order Mr. Arege's name be removed from the Registry.[17]

Conclusion

For the foregoing reasons, the Decision is hereby REVERSED.

IT IS SO ORDERED.

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Judge William C. Carpenter, Jr.

[16] 11 Del. C. § 8564; 16 Del. C. §1132; *Holden*, 2005 WL 3194481 at *2 (Neglect was determined through establishing a standard of care through the internal facility policy that nurses were to follow. The appellant failed to call 911 or administer CPR despite the resident being in clear respiratory arrest, despite appellant's claim that the resident was "obviously dead," and despite the internal policy stating that was protocol.); *Lynch v. Ellis*, 2003 WL 22087629 (Del. Super. Ct.) (Neglect was shown through a number of actions committed by the nurse, namely that she left the resident alone in a bathroom with the water running in the tub, the resident received second and third degree burns when he attempted to enter the tub and the nurse failed to seek medical treatment for two days.).

[17] Upon finding Mr. Arege did not commit neglect, the Court need not delve into any of the factors the hearing officer reviewed in determining how long Mr. Arege's name should be placed on the Registry.